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No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED FOR REVIEW

Under the Medicare statute for the years under appeal, hospitals were to be reimbursed for their "reasonable cost" of providing services to Medicare patients. The question presented for review is whether clause (ii) of 42 U.S.C. § 1395x(v)(1)(A), which provides for "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," requires substantive adjustments to any individual provider's reimbursement when the regulatory methods for determining reasonable cost (including the cost limits and their exceptions) result in inadequate or excessive reimbursement for that provider.

LIST OF PARTIES

The petitioners are Good Samaritan Hospital, The Mary Lanning Memorial Hospital Association, Memorial Community Hospital, Inc., Memorial Hospital Of Dodge County, Memorial Hospital and St. Mary's Hospital.

The respondent is Louis W. Sullivan, M.D., Secretary of Health and Human Services.

RULE 29.1 LIST

The parent company of Good Samaritan Hospital is Good Samaritan Health Systems, Inc. The parent company of Memorial Community Hospital, Inc. is Memorial Community Health System, Inc. The parent company of St. Mary's Hospital is St. Elizabeth Health System.

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BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals is reported at 952 F.2d 1017 and is reprinted at Pet. App. 1a. The memorandum decision of the district court is reported at [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,400 (D. Neb. Feb. 16, 1990), and is reprinted at Pet. App. 19a.

JURISDICTION

The judgment of the court of appeals was entered on December 30, 1991. Pet. App. 1a. A timely petition for rehearing was denied on February 7, 1992. Pet. App. 18a. On April 28, 1992, Justice Blackmun granted an extension of time to file the petition for certiorari until July 6, 1992. The petition was filed on June 26, 1992, and was granted on October 13,

1992. The jurisdiction of this Court rests upon 28 U.S.C. § 1254(l) (1992).

STATUTORY PROVISION INVOLVED

42 U.S.C. § 1395x(v) Reasonable costs

(1) (A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method

reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

STATEMENT OF THE CASE

Medicare Statutory And Regulatory Framework

For the cost reporting periods under appeal in this case (fiscal years 1980-1983), the Medicare statute required the Secretary of Health and Human Services to reimburse providers the lower of the "reasonable costs" of furnishing covered services to Medicare beneficiaries or the customary charge for such services. 42 U.S.C. § 1395f(b) (1992). "Reasonable cost" is defined as "the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services...." 42 U.S.C. § 1395x(v)(1)(A)(1992).[1]

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[1]For cost years beginning on or after October 1, 1983, most hospitals became subject to the Medicare prospective payment system (PPS), under which hospitals are paid a predetermined amount for each discharge, depending on the diagnosis of the patient. 42 U.S.C. § 1395ww(d) (1992). The first four years of PPS were transition years, during which

The Medicare statute directs the Secretary to establish a method or methods for calculating "reasonable costs." *Id.* However, the statute also requires the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining reasonable costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) (hereinafter "clause (ii)"). This requirement was in the original Medicare statute enacted in 1965. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 311 (1965).

One of the methods by which the Secretary determines reasonable cost is the application of "cost limits." The authority to establish these limits was contained in section 223 of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329. The Senate Committee explained that the cost limits were designed to prevent the reimbursement of costs attributable to inefficiency or the provision of luxury services, and were to be applied on a presumptive basis. S. Rep. No. 1230, 92d Cong., 2d Sess. 187, 188 (1972). The Committee further indicated that providers "would of course have the right to obtain reconsideration of their classification for purposes of the cost limits" and "to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." *Id.* at 189.

Pursuant to this statutory authority, in 1974 the Secretary first promulgated regulations establishing limits on hospital costs and certain exceptions thereto. 42 C.F.R. § 405.460.[2]

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a portion of a provider's payment was based upon its "reasonable cost" in its base year (generally FY 1982).

[2] The regulations were originally codified at 20 C.F.R. § 405.460 (1974) and are now codified at 42 C.F.R. § 413.30 (1991). Because the case law and the administrative record herein refer to 42 C.F.R. § 405.460, that designation is used throughout the brief.

See 39 Fed. Reg. 20164 (1974). Since that time schedules of hospital routine cost limits have been published annually.

The Secretary's cost limit regulations for the years at issue here classified hospitals as either urban (*i.e.*, located in a Standard Metropolitan Statistical Area ("SMSA")) or rural (*i.e.*, not in a SMSA). Beginning with cost reporting periods starting on or after July 1, 1979, the cost limit regulations also used a "wage index" based on geographic location to determine the labor-related component of a provider's costs. Rural areas generally have a lower wage index than urban areas. The data used to develop the wage index, drawn from the Bureau of Labor Statistics ("BLS"), did not distinguish between part-time and full-time employees. As a result, the wage index was distorted downward for those areas that had a high proportion of part-time employees.[3] This distortion was known by the Secretary from the earliest use of the wage index.[4]

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[3] BLS received data on the total hospital wages paid during the quarter, and the total number of hospital employees working during the month. From these data, BLS computed an "average monthly hospital wage" for each SMSA or each non-SMSA county. However, the "number of employees" counted all personnel, including part-time employees, equally. (A.R. 184).

The effect of this failure to distinguish part-time from full-time employees is best illustrated by a simple example. Assume that a county has one hospital which has total monthly wages of $100,000 and employed 100 full-time employees. BLS would calculate the average monthly hospital wage for the county as $1000 per month. However, if the hospital with the same $100,000 payroll employed 200 part-time employees, BLS would calculate the average monthly hospital wage for the county to be only $500 per month. As HCFA stated in an internal memorandum dated July 1, 1881, the effect of counting part-time workers the same as full-time workers is that "the wage index will be distorted to the extent various areas employ different proportions of part-time workers. The result can be the application of a lower cost limit to some hospitals then [sic] is warranted by real differences in wage levels." (Plaintiffs' Motion For Summary Judgment, Exhibit D.)

[4] *See* Exhibits A, C, D, and G to Plaintiffs' Motion for Summary Judgment; Rulemaking Record (R.R.) filed by the Secretary at 1237, 1238, 1393, 1469, 1072, 1393.

One part of the cost limits regulations for determining reasonable costs permits selected providers who fall within certain narrow categories to request a reclassification, exemption or exception from the limits. 42 C.F.R. § 405.460(d), (e) and (f). As the parties agree, Pet. App. 4a, n.4, none of these provisions permit relief from the cost limits based on a showing that the cost limits fail to account for reasonable necessary expenditures on behalf of Medicare beneficiaries. In particular, as relevant here, the regulations make no allowance for a provider to show that the use of many part-time employees is reasonable or for a rural hospital to show that it has to offer wages comparable to a nearby urban hospital to compete for employees in times of shortages. Thus, under the regulations as the Secretary applies them, unless a provider's claim for relief qualifies as one of the narrow exemptions or exceptions set forth in the regulation, no relief is available in the form of a retroactive corrective adjustment when the reimbursement proves to be inadequate to cover a provider's reasonable costs.

This Litigation

Each of the petitioners is classified as a rural Nebraska hospital for Medicare purposes. Hospitals in rural Nebraska as a whole, including petitioners, employ a percentage of part-time employees that is significantly higher than the national average. A.R. 129, 132.[5] Due to a nursing shortage, these rural hospitals also offered wages comparable to urban hospitals in an effort to attract needed staff.[6]

Prior to the cost years at issue, when the cost limits did not use a wage index, each of the petitioners' costs were below the

[5]"A.R." denotes the Administrative Record filed by the Secretary. The percentages of part-time employees used by the individual petitioners are found at A.R. 126, 420, 531, 690, 823, 925.

[6]A.R. 126, 420, 531, 690, 822, 925.

cost limits. When the methodology was changed to incorporate the wage index, each of the petitioners exceeded the rural Nebraska Medicare cost limits for the first time, although nothing had changed in their method of providing services. This occurred primarily because the wage index component of the cost limits did not account for the use of part-time employees. There is no evidence in the record, or suggestion by the Secretary, indicating that the petitioners' costs were unnecessary, or were incurred as a result of inefficiency or the provision of luxurious services, or that the use of part-time employees was inefficient. A.R. 292. To the contrary, in rural areas the use of part-time employees promotes efficiency and helps to hold down costs.

Pursuant to 42 U.S.C. § 1395oo (1992), each of the petitioners filed an appeal to the Provider Reimbursement Review Board ("PRRB") for the years in which they exceeded the cost limits (FYEs 1980-1983). The hospitals contended in their appeals that their costs in excess of the cost limits were nonetheless reasonable. They challenged the validity of the Medicare cost limits, claiming that they (1) did not account for the use of part-time employees and (2) did not permit rural hospitals to show that their circumstances required them to incur wage costs similar to those of urban hospitals. In addition, the hospitals claimed that the cost limits were applied in a conclusive rather than a presumptive fashion, because there was no regulatory mechanism by which the providers could obtain relief from the limits for these unavoidable expenses. They also claimed that, even if the cost limits were found to be valid as across-the-board regulations, the petitioners were entitled to individual retroactive corrective adjustment to their aggregate reimbursement under clause (ii) because their costs over the limits were reasonable.[7] A.R. 38, 372, 465, 605, 733, 878.

[7]In addition, petitioner Memorial Community Hospital challenged the Secretary's denial of its request for reclassification from "rural" hospital

The Board took jurisdiction over the appeals of the six hospitals, for a total of twenty cost years.[8] Pet. App. 37a-45a. Because the Board could not invalidate the Secretary's cost limits regulations, 42 C.F.R. § 405.1867 (1991), and did not believe it could award reimbursement in excess of the cost limits, the Board determined that it did not have the authority to grant the hospitals the relief they sought; *i.e.*, reimbursement over the cost limits. The Board therefore granted the hospitals' requests for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1) (1992), thereby allowing the hospitals to take their challenge directly into district court. *Id.*

On cross-motions for summary judgment, the district court agreed with the hospitals that the statute required the cost limits to be applied only on a presumptive rather than a conclusive basis. Pet. App. 26a. The court held that clause (ii) required the Secretary to make a retroactive adjustment to the providers' reimbursement where the Secretary's cost limits method, even though valid, resulted in inadequate reimbursement of the providers' individual aggregate reasonable costs. In so holding, the court relied on the prior decision of the Eighth Circuit in *St. Paul-Ramsey Medical Center v. Bowen*, 816 F.2d 417 (8th Cir. 1987).[9] Pet. App. 29a.

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status to "urban" hospital status. Both the district court and the court of appeals ruled against Memorial Community Hospital on this issue, and it is not now before the Court.

[8]The Board denied jurisdiction over three cost years on the ground that the appeals for those years were not timely filed. That issue is not before the Court.

[9]Other courts of appeals similarly have held that under clause (ii) the Secretary is required to make a retroactive adjustment when a provider receives reimbursement that is lesser or greater than its actual, reasonable cost, as calculated under the cost limits and any other method for determining reasonable cost. *See Medical Center Hospital v. Bowen*, 839 F.2d 1504 (11th Cir. 1988); *Regents of the University of California v. Heckler*, 771 F.2d 1182 (9th Cir. 1985); *Springdale Convalescent*

The district court rejected the Secretary's contention that *St. Paul-Ramsey* was no longer good law after this Court's decision in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988) (hereinafter "*Georgetown*"). Pet. App. 31a. The Secretary argued that *Georgetown* meant that clause (ii) only required year-end book-balancing to reconcile a provider's interim payments received during the year with the amount due a provider at the end of the year under the regulations. The district court disagreed, holding that *Georgetown* established only that clause (ii) does not authorize retroactive *rulemaking* and did not alter *St. Paul-Ramsey's* conclusions that clause (ii) does require *case-by-case adjustments* for individual providers of the kind the hospitals seek, where the regulatory methods, though valid, result in inadequate reimbursement. *Id.* The district court accordingly remanded the case to the Secretary "for a hearing from which he (1) shall apply to the cost years under appeal a wage index which takes into account the high use of part-time employees by hospitals in Nebraska and (2) shall consider the non-MSA designation of the [hospitals] in determining whether the aggregate reimbursement produced by the methods of determining costs has proved to be inadequate." J. A. 30.

The court of appeals reversed, holding that the hospitals were not entitled to a suitable retroactive corrective adjustment where the cost limits regulation resulted in inadequate reimbursement. The court concluded that its prior interpretation of clause (ii) in *St. Paul-Ramsey* had been overruled by the Supreme Court's decision in *Georgetown*. Pet. App. 11a.

Center v. Mathews, 545 F.2d 943 (5th Cir. 1977); *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973). Prior to 1988, only one court had held that clause (ii) is limited to year-end book-balancing. *Daughters of Miriam Center for the Aged v. Mathews*, 590 F.2d 1250 (3d Cir. 1978).

It read *Georgetown* as holding that the retroactive corrective adjustment required by clause (ii) is limited to year-end "book-balancing" to reconcile the monthly interim estimated payments a provider receives during the year with the amounts actually due for the year pursuant to the Secretary's methods of determining reasonable cost. Pet. App. 12a. It therefore concluded that the kind of retroactive corrective adjustment sought by the plaintiffs, which would reimburse costs over the cost limits, would amount to retroactive rulemaking that *Georgetown* prohibited.[10] Pet. App. 13a. In short, the court held that the petitioners were not entitled to a determination of whether their reimbursement was reasonable.[11]

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[10]The D.C. Circuit in *Hennepin County v. Sullivan*, 883 F.2d 85 (D.C. Cir. 1989), *cert. denied*, 493 U.S. 1043 (1990), also interpreted *Georgetown*'s observation regarding the Secretary's past position as a holding that clause (ii) only permits the Secretary to perform year-end book-balancing. In contrast, the Ninth Circuit expressly rejected this interpretation of *Georgetown* in *Mt. Diablo Hospital v. Sullivan*, 963 F.2d 1175 (9th Cir. 1992), *pet. for cert. filed*, 61 U.S.L.W. 3356 (U.S. October 22, 1992) (No. 92-720) (Pet. App. 54a), a case which also involves a challenge to the cost limits for failure to account for part-time employees. Instead, the Ninth Circuit held that *Georgetown* did not overrule its earlier decision in *Regents of the University of California v. Heckler*, 771 F.2d 1182 (9th Cir. 1985), which interpreted clause (ii) to require the Secretary to make a retroactive adjustment to reimburse a provider for all its "reasonable costs," even if those costs exceeded the cost limits and do not qualify for treatment as an exception or exemption under the Secretary's regulations.

[11]The court of appeals further held that the Secretary's cost limit methodology was valid and reasonable. Pet. App. 14a. Although the BLS data used for the wage index did not account for the difference between full-time and part-time employees, the court deferred to the Secretary's conclusion that they were the best data then available. Petitioners do not challenge that holding before the Court. However, the conclusive application of the cost limits to prevent reimbursement of reasonable costs which exceed the limits is intertwined with the petitioners' arguments on clause (ii) and is therefore before the Court.

SUMMARY OF ARGUMENT

The plain language of clause (ii), this Court's reading of clause (ii) in *Georgetown* and the legislative history of the cost limit regulations argue for providing petitioners the relief they seek.

The petitioners contend that the plain meaning of clause (ii) requires retroactive adjustments to individual providers when the Secretary's cost determination methods result in reimbursement of less than reasonable costs. In *Georgetown*, this Court expressly and repeatedly confirmed that clause (ii) requires substantive adjustments to the reimbursement of individual providers when the Secretary's methods produce inadequate reimbursement. The command of clause (ii) is not met simply by calculating the amounts due pursuant to the methods.

The legislative history of the 1972 Amendments to the Social Security Act which established the cost limits shows that Congress recognized that across-the-board cost limits could only be employed if individual providers had an opportunity to seek relief. The congressional committees debating the cost limits approach recognized the value of general cost limitations in streamlining the cost determination process. At the same time, however, the committees made clear their intent that any provider—not just some—should be permitted to prove costs in excess of the limits were necessary and justified. Never in the debate on this issue did Congress abandon the principle of reasonable cost reimbursement for *all* providers.

Only through "interpretative gymnastics" does the Secretary arrive at his position that clause (ii) means procedural year-end book-balancing, and that relief from the cost limits is available only to the relatively few providers who meet the Secretary's narrow regulatory exceptions. Such a construction violates all accepted standards of statutory construction.

An adjudication by the PRRB of the adequacy of an individual hospital's reimbursement as called for by clause (ii) would not

involve the Secretary in retroactive rulemaking. Clause (ii) does not authorize the making of new rules to govern past conduct. Nor do the petitioners seek any such new rules. Instead, they seek only the individualized adjudication necessary to obtain adequate reimbursement of reasonable costs, a process this Court in *Georgetown* clearly distinguished from rulemaking.

No deference should be accorded the Secretary's interpretation of clause (ii) or his position that relief under the cost limits should be available only to the few falling within the Secretary's exceptions. These contentions not only strain the plain meaning of the statute and fail to effect legislative intent, they run counter to *Georgetown*'s construction of clause (ii) and the Secretary's own actions. In fact, the Secretary's construction of clause (ii) in this case as requiring no more than year-end book-balancing is but one more in a long series of different interpretations by the Secretary that appear driven by the exigencies of whatever litigation is at hand.

ARGUMENT

A. The Plain Meaning Of Clause (ii), As Expressly Confirmed By *Georgetown*, Entitles Any Provider To Adjustment Of Its Reimbursement To Reflect Reasonable Costs Even If Above Regulatory Cost Limits.

The plain language of clause (ii) entitles petitioners to an adjustment of the amount provided them under the Secretary's regulations if that amount does not reimburse them for their reasonable costs. That is precisely how this Court read clause (ii) in *Georgetown*. And the Secretary's effort to restrict clause (ii) to computing the amounts due under the regulations, regardless of reasonable cost shortfalls, runs squarely counter to the language of clause (ii).[12]

[12]Clause (ii) also authorizes adjustments when payments made under the regulatory methods prove "excessive." For simplicity , we focus only on the situation where payments prove "inadequate."

1. The Plain Meaning Of Clause (ii) Authorizes Adjustments Of Reimbursements Where The Cost Limits, As Applied In A Particular Case, Produce An Underpayment.

Clause (ii) states that the Secretary shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." This sentence has a plain meaning. *See Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 669 (2d Cir. 1973) ("its plain words do not require interpretative gymnastics"). It states that a provider is entitled to have its reimbursement adjusted where the cost determination methods set forth in the regulations, including the cost limits with their exceptions, have produced an inadequate payment—where the "reimbursement produced by the methods of determining costs" turns out to be "inadequate" under the substantive standard of "reasonable costs" (§ 1395x(v)(1)(A)).

By its terms, the adjustment that clause (ii) provides for is available to any provider, not just to those providers that qualify for relief under the exceptions section of the Secretary's cost limits methodology. And the adjustment is in no way limited to mere recomputations to reconcile interim payments with the total amount due *under* the regulatory methods. Clause (ii) says explicitly that adjustment is available when the *methods themselves* produce an inadequate result.[13]

[13]Even the Secretary once recognized that this is the plain meaning. In *Humana of Illinois, Inc. v. Heckler*, No. 84-1727 (7th Cir.), consolidated with *St. James Hospital v. Heckler*, 760 F.2d 1460 (7th Cir. 1985), *cert. denied*, 474 U.S. 902 (1985), the Secretary acknowledged in his brief that clause (ii) provides "that retroactive adjustments must be made where reimbursement under the Secretary's regulations is otherwise inadequate." This argument closed with the following statement:

> To emphasize that this is indeed the interpretation of the Secretary, this brief has been signed by her legal representatives

2. *Georgetown* Expressly And Repeatedly Confirms This Plain Meaning.

In *Georgetown*, this Court rejected the Secretary's contention that clause (ii) authorized across-the-board retroactive rulemaking. 488 U.S. at 209. In so doing, the Court read clause (ii) exactly as we suggest. Thus, having noted that the cost limit regulations were among the "methods of determining costs," *id.* at 210, the Court concluded that, while the *methods* of reimbursement are not subject to retroactive alteration under clause (ii), that provision does authorize adjustments for individual providers when the generally applicable methods produce aggregate reimbursement that does not cover (or that exceeds) reasonable costs.

First, the Court said:

> we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making *case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases.* The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking.

Id. at 209 (emphasis added). Second, the Court stated that the adjustments mandated by clause (ii) "are required when, for 'a provider,' the 'aggregate reimbursement produced by the methods of determining costs' is too low or too high." *Id.* at 210. Again, in elaborating this point, the Court stated that clause (ii),

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within the Department of HHS, as well as by the Department of Justice.

See Reply Brief for Appellants/Cross-Appellees in Eighth Circuit case below, pp. 18-19 and referenced Exhibit.

> rather than permitting modifications to the cost-method rules in their general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers. Indeed, it is difficult to see how a corrective adjustment could be made to the aggregate reimbursement paid 'a provider' without performing an individual examination of the provider's expenditures in retrospect.

Id. And finally, the Court explained:

> It is also significant that clause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the methods of determining costs. As the Secretary concedes, the cost-limit rules are one of the methods of determining costs, and the retroactive 1984 rule was therefore an attempt to change one of those methods. Yet nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods.

Id. at 211.

In short, to explain its holding that clause (ii) does not authorize across-the-board retroactive rulemaking (*i.e.*, adoption of new general rules or "methods" to govern past conduct), this Court in *Georgetown* construed clause (ii) according to its plain meaning—as requiring adjustments to the reimbursement of individual providers (which effect no change in the regulatory methods themselves) when the Secretary's methods produce inadequate reimbursement of reasonable costs. That is precisely the reading that the Eighth Circuit rejected in this case. Thus, far from supporting the Eighth Circuit's decision, *Georgetown* flatly contradicts that decision, and squarely supports the plain meaning interpretation we urge.

B. Congress Intended Case-By-Case Adjustments To Be Made Where The Regulatory Cost Limits Prove Inadequate In A Particular Case.

To begin with, it is obvious from the face of the statute that Congress intended that individual providers have the opportunity on a case-by-case basis to ensure that their payments reimburse them for their reasonable costs. Even aside from the plain meaning of clause (ii), this is the fundamental principle of the individualized "reasonable cost" standard of § 1395(v)(1)(A). That section expressly states that the reasonable costs of treating Medicare patients should be paid so that those costs do not end up being borne by non-Medicare patients—an inevitable consequence of refusing to allow adjustments to correct underpayments, even where they result from general regulatory limits. And that principle necessarily means that the reimbursement produced by the regulatory methods must be subject to adjustment in particular cases on the ground that the regulations produce an inadequate payment.

In 1965 when clause (ii) was enacted as part of the original Medicare statute (Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 311 (1965)), Congress clearly intended that the reasonable cost method would reimburse each provider's actual reasonable costs.[14] Nothing changed in this principle when Congress provided for the cost

[14]S. Rep. No. 404, 89th Cong., 1st Sess. 35 (1965) *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976 ("The provision in the bill for the payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization and other relevant factors."); *see also*, H.R. Rep. No. 213, 89th Cong., 1st Sess. at 31 (1965). This principle was incorporated into the Secretary's regulations at 20 C.F.R. § 405.451 (1966), *redesignated* 42 C.F.R. § 405.451 (1977), *redesignated* 42 C.F.R. § 413.9 (1986).

limits in 1972. Congress did not abandon this right of providers ultimately to obtain individualized assessments of their reasonable costs, for it left clause (ii) in tact. Instead, Congress' aim was to make the process of determining unreasonable costs more efficient and thereby strengthen the Secretary's authority to deny reimbursement for unnecessary or inefficiently incurred costs. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 40, 187 (1972); H.R. Rep. No. 231, 92d Cong., 2d Sess. 82 (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5069.

The legislative history makes clear that the cost limits were intended to prevent reimbursement *only* of costs resulting from "marked inefficiency" or from the provision of "excessive," luxurious services and that "only cases with extraordinary expenses would be subject to the limit." S. Rep. No. 1230, 92d Cong., 2d Sess. 187 (1972). The Finance Committee specifically acknowledged that costs of health care could vary for reasons other than inefficiency or excessive services, *e.g.*, "size of institution, patient mix, scope of services rendered or other economic factors." *Id.* Nothing suggests it intended that cost reduction efforts such as the use of part-time employees, or paying urban wages in a rural area to attract needed employees during a manpower shortage, should result in a limit on reimbursement.

The congressional committees made clear that the new cost limits were "presumptive." S. Rep. No. 1230, *supra*, at 188. They explained: "Providers would of course have the right to obtain reconsideration of their classification for purposes of the cost limits applied to them and to obtain relief the effect of the cost limits on the basis of evidence of the need for such an exception." *Id.* at 189. *See also* H.R. Rep. No. 231, 92nd Cong., 2d Sess. 85 (1972), *reprinted in* 1972 U.S.C.C.A.N. at 5071 (identical language).

The function of the new cost limits method was thus not to deprive providers of the opportunity for individualized relief. Instead, the cost limits methodology simply enabled inter-

mediaries to disallow costs in excess of the limits in the first instance without having to engage in a case-specific evaluation of reasonableness. Before the adoption of the cost limits, an intermediary could disallow costs as unreasonable only to the extent it could establish that a provider's costs were "substantially out of line" with comparable facilities in the same geographic area. 20 C.F.R. § 405.451(c)(2) (1967). Congress recognized that this approach placed a difficult burden of proof on the intermediary. *See* H.R. Rep. 231, *supra*, at 83, *reprinted in* 1972 U.S.C.C.A.N. at 5069-5070 ("Present law generally limits exercise of the authority to disallow costs to instances that can be specifically proven on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult."). With the cost limits in place, the provider was required to demonstrate that costs over the limits should be allowed, rather than the intermediary having to demonstrate that such costs should be disallowed. *Medical Center Hospital*, 839 F.2d at 1513.[15]

In the present case, the petitioners have justified their need for reimbursement over the cost limits. They have demonstrated that the cost limits methodology produced inadequate payments by failing to account for use of part-time employees and for the need of some rural hospitals to offer wages comparable to those paid by nearby urban hospitals. In this situation, in order to prevent non-Medicare patients from having to bear unreimbursed costs, Congress intended the Secretary to adjust the providers' aggregate reimbursement.

[15]Contrary to the government's suggestion (Br. of Resp. at 9 n.5), a plain reading of clause (ii) does not give providers an incentive to operate inefficiently "by encouraging providers to seek additional reimbursement whenever their costs exceed the Secretary's cost limits." Inefficiently incurred costs, of course, could not be reimbursed as "reasonable costs" through the adjustment process or otherwise.

C. Adjustments Under Clause (ii) Are Not Limited To Year-End Book-Balancing.

The Secretary contends that clause (ii) adjustments are limited to end-of-the-year book-balancing to reconcile the interim payments a hospital receives during a year with the amount that is due to the provider by the proper application of the reasonable cost regulations at the end of the year, after a cost report is filed.[16] Br. of Resp. at 8-9. This reading ignores the language of clause (ii), which says that an adjustment is required when the "methods of determining costs" produce an underpayment. The provision refers to *all* of the methods described in the immediately preceding sentences of § 1395x(v)(1)(A), which includes all of the cost limits and exceptions set forth in the Secretary's regulations. *See Georgetown*, 488 U.S. at 210 (section 1395x(v)(1)(A) "directs the Secretary to promulgate regulations (including cost-limit rules) establishing the methods to be used in determining reasonable costs").

Clause (ii) thus authorizes adjustments when the whole panoply of regulations produces inadequate reimbursement in a particular case. It does not apply to year-end reconciliation, for the interim payment process is not a "method" of determining reasonable cost. The interim payment process is nothing more than a mechanism to generate cash flow for

[16]The book-balancing regulations provide, in relevant part: "These regulations also provide for the making of suitable retroactive corrective adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both [the Medicare program] and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year." 20 C.F.R. § 405.451(b)(1)(1967), *redesignated* 42 C.F.R. § 405.451(b)(1)(1977), *redesignated* 42 C.F.R. § 413.9(b)(1986). *See also* 20 C.F.R. § 405.454(f)(1967), *redesignated* 42 C.F.R. § 405.454(f)(1977), *redesignated* 42 C.F.R. § 413.64(f)(1986).

providers until the reasonable costs of providing services can be determined at the close of the year, and has no function or relationship to the process of determining whether the costs claimed on the annual cost report are reasonable. While this year-end reconciliation process may involve a retroactive adjustment, it does *not* accomplish the central test that is required by the plain language of clause (ii): to determine on a case-by-case basis whether the aggregate reimbursement produced by the *methods themselves* is sufficient to reimburse an individual provider for its "reasonable costs."

Indeed, year-end book-balancing is not the subject of clause (ii) at all. It is 42 U.S.C. § 1395g (1992), entitled "payments to providers of services," that addresses, in detail, the entire subject of interim payments and end-of-year book-balancing.[17] The Secretary's reading would thus not only run counter to the test of clause (ii) but render it largely redundant, contrary to a cardinal principle of statutory construction. *See, e.g., United States v. Nordic Village, Inc.*, 112 S. Ct. 1011, 1015 (1992); *Colautti v. Franklin*, 439 U.S. 379, 392 (1979).[18]

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[17] Subsection (a) of § 1395g expressly provides for *both* interim payments during the year *and* end-of-year reconciliation:

> (1) Determination of amount. The Secretary shall periodically determine the amount which should be paid under [Part A] to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, *with necessary adjustments on account of previously made overpayments or underpayments*; ... [Emphasis added.]

[18] In the course of its discussion, the *Georgetown* Court noted that in the past the *Secretary* had interpreted clause (ii) to require only year-end reconciliation. *Id.* at 211 and n.2. It made this statement only as justification for not deferring to the Secretary's position in *Georgetown* that clause (ii) authorized retroactive rulemaking, not to endorse the Secretary's interpretation that clause (ii) requires no more than year-end book-balancing. The Court in *Georgetown* did not examine the precise contours and operation of the book-balancing regulations to determine whether they were in fact a valid implementation of clause (ii). Nor did the Court analyze whether the proper authority for the book-balancing regulations was 42 U.S.C. § 1395g, which provides for both interim payments and year-end reconciliation. Those issues were not before the Court. Accordingly, the Court's discussion of the book-balancing regulations in *Georgetown* at most is dicta and cannot be construed as approval of the Secretary's limited "book-balancing" construction of clause (ii), for such a reading would contradict the point repeatedly made in *Georgetown's* text—that clause (ii) authorizes adjustments *beyond* the regulatory limits.

D. The Exceptions Provided In The Cost Limits Regulation Are Not The Mechanism To Implement Clause (ii).

As part of the cost limits method at § 405.460, the Secretary provided for certain very narrow exceptions to the limits. In his Brief in Response to the Petition for Certiorari, the Secretary argues that these exceptions fully satisfy his duty to make the cost limits presumptive. Br. of Resp. at 10. He also argued, in *Medical Center Hospital v. Bowen*, 839 F.2d 1504, 1511 (11th Cir. 1988), that providing a process for selective exceptions to the limits satisfies his duty under clause (ii) for retroactive corrective adjustments.

These arguments fail for two reasons. First, the exceptions themselves are part of the cost limits regulation. The regulation, including the exceptions thereto, constitute one of the "methods" of determining reasonable costs that is subject to the overriding requirement that "corrective adjustments" be made *whenever* the actual aggregate reasonable costs exceed the reimbursement due under an established method. *Regents of the University of California v. Heckler*, 771 F.2d at 1190-91.

Second, the exceptions provision of the cost limit regulations cannot satisfy the mandate in clause (ii) for "corrective adjustments" because relief under the provision would then be limited to those providers with reimbursement shortfalls falling

within the exceptions' narrow scope.[19] Both the plain language of clause (ii) and the legislative history of the cost limits, *supra* p. 16, indicate that, owing to their presumptive nature, *any* provider may receive reimbursement over the limits if the provider can justify the reasonableness of its costs. *See Medical Center Hospital*, 839 F.2d at 1511 ("We can imagine myriad situations where resort to the Secretary's [cost limits] exceptions process would not result in the provider receiving the full reimbursement to which it is entitled under the statute.").

Moreover, the exact wording of clause (ii) requires the Secretary to provide suitable adjustments for "a provider" of services. The Secretary would construe this phrase to mean only "some" providers, *i.e.*, only those qualifying under the narrow exceptions that are part of the cost limits method. No support exists for such an interpretation which strains all accepted rules of statutory construction.

Thus, exceptions to the cost limits cannot be limited to those few situations provided in the regulations at 42 C.F.R. § 405.460. Rather, owing to their presumptive nature, the cost limits may be rebutted by any provider that can demonstrate that the cost limits methodology produced an incorrect result and that its incurred costs are reasonable.

[19]The parties agree that none of the regulatory exceptions to the cost limits provide relief to the Hospitals. Pet. App. at 4a. The petitioners' fiscal intermediary stated to one of the petitioners, "As far as the [cost limits] exceptions noted on page three of [HCFA's] letter [denying relief for the wage index issues] go - I haven't found any in Nebraska that HCFA will accept." A.R. 162. Indeed, HCFA flatly stated that a challenge to the cost limit methodology "is beyond the scope of any basis for an exception provided under § 405.460(f) of the Medicare regulations." A.R. 164.

E. Deference To The Secretary Cannot Justify Reading Clause (ii) Contrary To Its Language And Purpose.

1. To the extent that the Secretary claims that its year-end book-balancing regulation embodies an interpretation of clause (ii) to which deference is owed, that position is wrong on several grounds. For one thing, the regulation cannot control where it is contrary to the meaning of the statute as drawn using the usual methods of statutory construction, including its language and purpose. *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984); *FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981); *SEC v. Sloan*, 436 U.S. 103, 117-118 (1978); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 745-746 (1973). This is especially so where the statute has already been authoritatively construed by this Court, as clause (ii) was in *Georgetown*. *See Lechmere, Inc. v. NLRB*, 112 S. Ct. 841, 847-48 (1992); *Maislin Industries, U.S., Inc. v. Primary Steel, Inc.*, 110 S. Ct. 2759, 2768 (1990).

In fact, treating the book-balancing regulations as embodying an authoritative interpretation of clause (ii) would make clause (ii) mere surplusage. As set forth above, the whole subject of year-end book-balancing is addressed by § 1395g, not by clause (ii). *See* page 20, *supra*.

2. The inconsistency of the Secretary's positions on the meaning of clause (ii) also undermines any claim to deference the Secretary may advance. *Pauley v. Bethenergy Mines, Inc.*, 111 S. Ct. 2524, 2535 (1991). While the Secretary has here construed clause (ii) as authorizing only year-end book-balancing, he has taken different "convenient litigating position[s]" in other cases. *Georgetown*, 488 U.S. at 213.

(a) In *Georgetown*, the Secretary argued that clause (ii) empowers him to issue legislative across-the-board rules with retroactive effect.[20] 488 U.S. at 209.

[20]*Accord, Medical Center Hospital*, 839 F.2d at 1513 n.14, where the Secretary was unwilling to concede that he has *ever* interpreted clause (ii) to require any provider-specific adjustments, presumably including year-end reconciliations.

(b) In *Medical Center Hospital*, the Secretary argued that clause (ii) is satisfied by the so-called cost limits "exceptions process" established in 42 C.F.R. § 405.460. 839 F.2d at 1511.

(c) In *Mercy Community Hospital v. Blue Cross Association/ Blue Cross of Florida, Inc.*, HCFA Dep. Admin. Dec., [1983-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 32,316 at 9542 (Nov. 4, 1982), the Secretary argued that clause (ii) authorized the regulation at 42 C.F.R. § 405.415(f), which "provides for a retroactive corrective adjustment [for individual providers] when a depreciable asset is sold at a gain or a loss," and in *Springdale Convalescent Center*, 545 F.2d at 954, he argued it authorized the regulation at § 405.415(d)(3), which permits Medicare to recoup the difference between accelerated and straight-line depreciation when a provider leaves the Medicare program.

(d) In *Humana of Illinois, Inc. v. Heckler*, No. 84-1727 (7th Cir.), consolidated with *St. James Hospital v. Heckler*, 760 F.2d 1460 (7th Cir. 1985), *cert. denied*, 474 U.S. 902 (1985), the Secretary stated in his brief that clause (ii) provides "that retroactive adjustments must be made where reimbursement under the Secretary's regulations is otherwise inadequate." *See* n. 10, *supra*.

Most significantly, even after *Georgetown* the Secretary has failed to follow his current interpretation that year-end book-balancing is the only retroactive adjustment permitted by clause (ii). In *Sutter Community Hospitals, et al. v. Heckler*, No. 5-82-204 (E.D. Cal. 1984), *aff'd*, Nos. 84-1900 and 84-1852 (9th Cir. 1985), the court held that clause (ii) required that the providers be given an opportunity to demonstrate that their costs in excess of the cost limits were reasonable, and remanded the case to the Provider Reimbursement Review Board for a hearing. At the conclusion of the hearing process where the providers presented evidence to support the reasonableness of their costs in excess of the limits, the PRRB ruled in favor of

the providers. PRRB Decisions Nos. 89-D69/89-D73, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶¶ 38,228-38,229 (September 28, 1989).

Nearly a year after *Georgetown* was decided, the HCFA Administrator, as the Secretary's delegate, affirmed the PRRB decisions in the *Sutter* cases. HCFA Administrator Decision, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,279 (Nov. 27, 1989). His affirmance assumed the authority of the PRRB to make adjustments to the providers' costs. He did not have to do so, if he interpreted *Georgetown* to hold that clause (ii) only required book-balancing. *See Chicago and North Western Transportation Co. v. United States*, 574 F.2d 926, 930 (7th Cir. 1978) (under law of the case doctrine, an administrative agency is bound on remand to apply principles laid down by court unless an intervening decision of the Supreme Court is inconsistent with remand order).[21]

3. Finally, any claim to deference to the Secretary's restrictive view of clause (ii) is undermined by the fact that there is a regulatory procedure designed for, and used for, the making of adjustments to correct inadequacies resulting from application of the regulatory methods. Thus, the adjustments can be and are made through the Provider Reimbursement Review Board ("PRRB") adjudicatory process. 42 C.F.R. §§ 405.1801-405.1890 (1991).

Section 1395oo(d) of the statute authorizes the PRRB to address claims for such adjustments when it authorizes the PRRB "to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost reports . . . even though such matters were not considered by

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[21] Even in a non-litigation context following *Georgetown*, the Secretary acknowledged that clause (ii) requires reimbursement of costs in excess of the cost limits, rather than mere book-balancing. *See* HCFA Ruling 89-2, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,236 (October 31, 1989).

the intermediary." Indeed, in *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 406 (1988), the Court's description of the PRRB's authority under § 1395oo(d) is expansive:

> This language allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The only limitation prescribed by Congress is that the matter must have been "covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.

That authority is sufficient to allow the PRRB directly to award an adjustment departing from the regulatory cost limits, notwithstanding the regulatory bar on the PRRB invalidating the Secretary's regulations. 42 C.F.R. § 405.1867. That bar, as this Court suggested in *Bethesda*, 485 U.S. at 406, is best read as forbidding the PRRB "to declare regulations invalid." A decision by the PRRB that a retroactive adjustment is warranted in a particular situation where presumptive cost limits result in inadequate reimbursement would not invalidate the regulations as generally applied.[22]

Significantly, the PRRB was created in the same legislation that authorized the cost limits. Pub. L. No. 92-603, §§ 223, 243, 86 Stat. 1329 at 1627, 1661 (1972). In addition, the timing of the PRRB regulations suggest that the PRRB is the regulatory mechanism to implement clause (ii). In 1973 the Second Circuit held in *Kingsbrook*, 486 F.2d at 669, that

[22]The Court of Appeals stated that any relief to the petitioners would constitute a "second bite of the apple," where the Court upheld the validity of the cost limits regulation. Pet. App. 149. This statement ignores the fact that clause (ii) requires such retroactive adjustments where *valid* methods of determining costs result in inadequate reimbursement.

clause (ii) required regulations for retroactive adjustments "to correct flaws in the aggregate reimbursement to which a provider is entitled due to an erroneous method of determining reimbursable costs." Having searched "in vain for such regulations," the *Kingsbrook* Court ordered the Secretary "to promulgate regulations consistent with the interpretation of section 1395x(v)(1) that we have announced." *Id.* at 670. The PRRB regulations, expressly invoking § 1395x(v) as well as § 1395oo as authority, were promulgated the next year. 39 Fed. Reg. 34515 (1974). The Secretary has promulgated no other regulations since that time in response to the *Kingsbrook* mandate that provide a process for individualized adjustments for any provider.

Against this background, it is hardly surprising that the PRRB has actually served as the mechanism for clause (ii) adjustments in a number of cases. *See Medical Center Hospital v. Bowen*, 839 F.2d 1504 (11th Cir. 1988); *Regents of the University of California v. Heckler*, 771 F.2d 1182 (9th Cir. 1985); *Sutter Community Hospitals, et al. v. Heckler*, No. 5-82-204 (E.D. Cal. 1984), *aff'd*, Nos. 84-1900 and 84-1852 (9th Cir. 1985). And in the *Sutter* cases, as discussed at p. 25, *supra*, the Administrator of HCFA affirmed the PRRB decisions which granted an adjustment from the results of applying the Secretary's cost limit regulations.

F. The Relief Petitioners Seek Would Not Amount To Retroactive Rulemaking.

The Eighth Circuit suggested that the relief petitioners seek would amount to retroactive rulemaking. Pet. App. 13a. Presumably, the court of appeals reasoned that, since *Georgetown* said that clause (ii) does not authorize such rulemaking, petitioners' reading of clause (ii) must be rejected. This is plainly wrong: the adjustment petitioners seek is not "rulemaking."

As this Court (and the concurring opinion) in *Georgetown* made unmistakably clear, there is a fundamental and dispositive distinction between rulemaking and adjudication. 488 U.S. at 209-210 (Scalia, J., concurring). What clause (ii) does not authorize, as *Georgetown* held, is the making of new general rules to govern past conduct. But petitioners do not seek any such new rules. Rather, they seek nothing more than an individualized *adjudication*. The effect of this determination is not to promulgate a new legislative rule or to invalidate the regulatory methods as valid *general* rules.

Moreover, all that petitioners seek is their rights under the law as it always existed for the 1980-1983 cost years: *i.e.*, they claim their right—not just under the regulations, but under the necessarily superior statutory "reasonable cost" standard—to the correct level of reimbursement. Thus, petitioners' reading of clause (ii) does not authorize imposition of a standard on this particular case that was not in existence at the time the services were delivered. The effect is simply to apply then-governing law ("reasonable cost") to one case.

Finally, of course, once the case-specific nature of the determination is recognized, any question about retroactivity is irrelevant. Clause (ii) expressly authorizes individual "retroactive corrective adjustments." Accordingly, the *Georgetown* principle disfavoring retroactive rulemaking offers no reason whatever for reading clause (ii) contrary to its plain meaning.

CONCLUSION

The petitioners request that the decision of the court of appeals be reversed and that this case be remanded to the Provider Reimbursement Review Board where the petitioners shall have the opportunity to demonstrate that their costs in excess of the cost limits are reasonable.

Respectfully submitted,

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